PAULA ACKER L.C.S.W INTAKE FORM

Name:_____

Date of Birth: ___/____/_____

Age_____

Gender: ☐ Male ☐ Female

Address _____

City _____ State _____ Zip_____

Email _____

Home Phone _____Work Phone _____

Cell Phone _____

Insurance Information Company _____ ID#_____ Group#_____

Occupation _____

Employer _____

Marital Status _____

Name of Spouse/Partner _____

How Long Have Both of You Been Together? _____

Religion _____

If Client is a Minor, Name of Responsible

Adult _____

Phone Contact _____

Address _____City _____ State _____Zip _____

Emergency Contact:_____ Phone:_____

There are times when prior medical and psychological records will be requested.
Please make sure that all information given below is correct.

Do You Smoke?_____How Much?_____

Do You Drink?_____ How Much? _____

Do You Take Drugs?_____If yes, what kind? _____

How often?_____

Last Medical Examination_____

Are you now under a doctor's care?_____

If yes, Doctor's name: _____

Reason for Doctor's care:_____

_____

Are You Taking Any Medication?_____If yes, what kind? _____

Reason for Medication: _____

Have You Ever Been Hospitalized for a Physical Illness? Describe:_____

_____

Have you ever been Hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, etc?

Describe: _____

_____

Any Previous Therapy/Counseling? _____If Yes, Name and Phone Numbers of Therapists: _____

_____

When and Number of Sessions: _____

Type of Therapy/Counseling: _____

How were you referred to Paula Acker L.C.S.W?_____

What do you Wish to Achieve with Therapy? _____

_____

_____

_____

_____

_____

_____

_____

_____

Check Any of the Following That May Apply to You:

☐	Headache	☐	Inferiority Feelings	☐	Shy With People
☐	Dizziness	☐	Feel Tense	☐	Can't Make Friends
☐	Fainting Spells	☐	Feel Panicky	☐	Afraid Of People
☐	No Appetite	☐	Fears and Phobias	☐	Home Conditions Bad
☐	Over-Eating	☐	Obsessions	☐	Unable To Have A Good Time
☐	Stomach Trouble	☐	Depressed	☐	Always Worried About Something
☐	Bowel Disturbances	☐	Suicidal Ideas	☐	Don't Like Weekends/Vacations
☐	Always Tired	☐	Dangerous Drugs	☐	Can't Make Decisions
☐	Unable To Relax	☐	Alcoholism	☐	Financial Problems
☐	Insomnia	☐	Allergy	☐	Gambling
☐	Recurrent Dreams	☐	Asthma	☐	Job Problems

Signature_____ Date_____